

AMENDED IN ASSEMBLY MAY 6, 2015

AMENDED IN SENATE APRIL 6, 2015

AMENDED IN SENATE FEBRUARY 26, 2015

SENATE BILL

No. 125

Introduced by Senator Hernandez

January 16, 2015

An act to amend Sections *1357.500*, *1399.849*, *127660*, *127662*, and *127664* of, and to repeal and add Section *127665* of, the Health and Safety Code, and to amend ~~Section~~ *Sections 10753 and 10965.3* of the Insurance Code, relating to health care coverage, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 125, as amended, Hernandez. Health care coverage.

(1) Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms as of January 1, 2014. Among other things, PPACA requires each health insurance issuer that offers health insurance coverage in the individual or group market in a state to accept every employer and individual in the state that applies for that coverage and to renew that coverage at the option of the plan sponsor or the individual.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer, on and after October 1, 2013, to offer, market, and sell all of the plan's insurer's health benefit

plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the plan or insurer provides or arranges for the provision of health care services, as specified, but requires plans and insurers to limit enrollment in individual health benefit plans to specified open enrollment and special enrollment periods. Existing law requires a plan or insurer to provide annual enrollment periods for policy years on or after January 1, 2016, from October 15 to December 7, inclusive, of the preceding calendar year.

This bill would instead require that those annual enrollment periods extend from November 1, of the preceding calendar year, to January 31 of the benefit year, inclusive. Because a willful violation of that requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.

(2) PPACA requires each state, by January 1, 2014, to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers. PPACA, in connection with state health benefit exchanges, defines a small employer to mean an employer who employed an average of at least one but not more than 100 employees on business days during the preceding calendar year, and requires the number of employees, for purposes of determining the size of the employer, to be determined using a counting method in which full-time equivalents are treated as full-time employees for plan years beginning on or after January 1, 2016.

Existing law establishes the California Health Benefit Exchange within state government for the purpose of facilitating the purchase of qualified health plans through the Exchange by qualified individuals and small employers. Existing law requires, on and after October 1, 2013, a health care service plan or health insurer to fairly and affirmatively offer, market, and sell all of the plan's or insurer's small employer plan contracts or health benefit plans for plan years on or after January 1, 2014, to all small employers in each service area or geographic region in which the plan or insurer provides or arranges for health care services or benefits. For plan years commencing on or after January 1, 2016, existing law defines a small employer to mean any person, firm, proprietary or nonprofit organization, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at

least one, but no more than 100, eligible full-time employees, as specified.

This bill would revise the definition of small employer, for plan years commencing on or after January 1, 2016, to instead require the use of the full-time equivalent employee counting method for determining the size of the employer, as specified under PPACA.

~~(2)~~

(3) Existing law establishes the California Health Benefit Review Program to assess legislation that proposes to mandate or repeal a mandated health benefit or service, as defined. Existing law requests the University of California to provide the analysis to the appropriate policy and fiscal committees of the Legislature within 60 days after receiving a request for the analysis. Existing law also requests that the university report to the Governor and the Legislature on the implementation of the program by January 1, 2014.

This bill would request the University of California to include essential health benefits and the impact on the California Health Benefit Exchange in the analysis prepared under the program. The bill would further request that the University of California assess legislation that impacts health insurance benefit design, cost sharing, premiums, and other health insurance topics. The bill would request that the university provide the analysis to the appropriate policy and fiscal committees of the Legislature not later than 60 days, or in a manner and pursuant to a timeline agreed to by the Legislature and the program, after receiving the request, as specified. The bill would also extend the date by which the university is requested to report to the Governor and the Legislature on the implementation program until January 1, 2017.

Existing law establishes the Health Care Benefits Fund to support the university in implementing the program. Existing law imposes an annual charge on health care service plans and health insurers, as specified, to be deposited into the fund. Existing law prohibits the total annual assessment pursuant to that provision from exceeding \$2,000,000. Under existing law, the fund and the program are repealed as of December 31, 2015.

This bill would extend until June 30, 2017, the operative date of the program and the fund, including the annual charge on health care service plans and health insurers. The bill would repeal the above-described provisions as of January 1, 2018.

~~(3)~~

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~(4)~~

(5) This bill would declare that it is to take effect immediately as an urgency statute.

Vote: $\frac{2}{3}$. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 *SECTION 1. Section 1357.500 of the Health and Safety Code*
2 *is amended to read:*

3 1357.500. As used in this article, the following definitions shall
4 apply:

5 (a) “Child” means a child described in Section 22775 of the
6 Government Code and subdivisions (n) to (p), inclusive, of Section
7 599.500 of Title 2 of the California Code of Regulations.

8 (b) “Dependent” means the spouse or registered domestic
9 partner, or child, of an eligible employee, subject to applicable
10 terms of the health care service plan contract covering the
11 employee, and includes dependents of guaranteed association
12 members if the association elects to include dependents under its
13 health coverage at the same time it determines its membership
14 composition pursuant to subdivision (m).

15 (c) “Eligible employee” means either of the following:

16 (1) Any permanent employee who is actively engaged on a
17 full-time basis in the conduct of the business of the small employer
18 with a normal workweek of an average of 30 hours per week over
19 the course of a month, at the small employer’s regular places of
20 business, who has met any statutorily authorized applicable waiting
21 period requirements. The term includes sole proprietors or partners
22 of a partnership, if they are actively engaged on a full-time basis
23 in the small employer’s business and included as employees under
24 a health care service plan contract of a small employer, but does
25 not include employees who work on a part-time, temporary, or
26 substitute basis. It includes any eligible employee, as defined in
27 this paragraph, who obtains coverage through a guaranteed

1 association. Employees of employers purchasing through a
2 guaranteed association shall be deemed to be eligible employees
3 if they would otherwise meet the definition except for the number
4 of persons employed by the employer. Permanent employees who
5 work at least 20 hours but not more than 29 hours are deemed to
6 be eligible employees if all four of the following apply:

7 (A) They otherwise meet the definition of an eligible employee
8 except for the number of hours worked.

9 (B) The employer offers the employees health coverage under
10 a health benefit plan.

11 (C) All similarly situated individuals are offered coverage under
12 the health benefit plan.

13 (D) The employee must have worked at least 20 hours per
14 normal workweek for at least 50 percent of the weeks in the
15 previous calendar quarter. The health care service plan may request
16 any necessary information to document the hours and time period
17 in question, including, but not limited to, payroll records and
18 employee wage and tax filings.

19 (2) Any member of a guaranteed association as defined in
20 subdivision (m).

21 (d) “Exchange” means the California Health Benefit Exchange
22 created by Section 100500 of the Government Code.

23 (e) “In force business” means an existing health benefit plan
24 contract issued by the plan to a small employer.

25 (f) “Late enrollee” means an eligible employee or dependent
26 who has declined enrollment in a health benefit plan offered by a
27 small employer at the time of the initial enrollment period provided
28 under the terms of the health benefit plan consistent with the
29 periods provided pursuant to Section 1357.503 and who
30 subsequently requests enrollment in a health benefit plan of that
31 small employer, except where the employee or dependent qualifies
32 for a special enrollment period provided pursuant to Section
33 1357.503. It also means any member of an association that is a
34 guaranteed association as well as any other person eligible to
35 purchase through the guaranteed association when that person has
36 failed to purchase coverage during the initial enrollment period
37 provided under the terms of the guaranteed association’s plan
38 contract consistent with the periods provided pursuant to Section
39 1357.503 and who subsequently requests enrollment in the plan,

1 except where that member or person qualifies for a special
2 enrollment period provided pursuant to Section 1357.503.

3 (g) “New business” means a health care service plan contract
4 issued to a small employer that is not the plan’s in force business.

5 (h) “Preexisting condition provision” means a contract provision
6 that excludes coverage for charges or expenses incurred during a
7 specified period following the enrollee’s effective date of coverage,
8 as to a condition for which medical advice, diagnosis, care, or
9 treatment was recommended or received during a specified period
10 immediately preceding the effective date of coverage. No health
11 care service plan shall limit or exclude coverage for any individual
12 based on a preexisting condition whether or not any medical advice,
13 diagnosis, care, or treatment was recommended or received before
14 that date.

15 (i) “Creditable coverage” means:

16 (1) Any individual or group policy, contract, or program that is
17 written or administered by a disability insurer, health care service
18 plan, fraternal benefits society, self-insured employer plan, or any
19 other entity, in this state or elsewhere, and that arranges or provides
20 medical, hospital, and surgical coverage not designed to supplement
21 other private or governmental plans. The term includes continuation
22 or conversion coverage but does not include accident only, credit,
23 coverage for onsite medical clinics, disability income, Medicare
24 supplement, long-term care, dental, vision, coverage issued as a
25 supplement to liability insurance, insurance arising out of a
26 workers’ compensation or similar law, automobile medical payment
27 insurance, or insurance under which benefits are payable with or
28 without regard to fault and that is statutorily required to be
29 contained in any liability insurance policy or equivalent
30 self-insurance.

31 (2) The Medicare program pursuant to Title XVIII of the federal
32 Social Security Act (42 U.S.C. Sec. 1395 et seq.).

33 (3) The Medicaid Program pursuant to Title XIX of the federal
34 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

35 (4) Any other publicly sponsored program, provided in this state
36 or elsewhere, of medical, hospital, and surgical care.

37 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
38 (Civilian Health and Medical Program of the Uniformed Services
39 (CHAMPUS)).

1 (6) A medical care program of the Indian Health Service or of
2 a tribal organization.

3 (7) A health plan offered under 5 U.S.C. Chapter 89
4 (commencing with Section 8901) (Federal Employees Health
5 Benefits Program (FEHBP)).

6 (8) A public health plan as defined in federal regulations
7 authorized by Section 2701(c)(1)(I) of the Public Health Service
8 Act, as amended by Public Law 104-191, the Health Insurance
9 Portability and Accountability Act of 1996.

10 (9) A health benefit plan under Section 5(e) of the Peace Corps
11 Act (22 U.S.C. Sec. 2504(e)).

12 (10) Any other creditable coverage as defined by subsection (c)
13 of Section 2704 of Title XXVII of the federal Public Health Service
14 Act (42 U.S.C. Sec. 300gg-3(c)).

15 (j) “Rating period” means the period for which premium rates
16 established by a plan are in effect and shall be no less than 12
17 months from the date of issuance or renewal of the plan contract.

18 (k) (1) “Small employer” means any of the following:

19 (A) For plan years commencing on or after January 1, 2014,
20 and on or before December 31, 2015, any person, firm, proprietary
21 or nonprofit corporation, partnership, public agency, or association
22 that is actively engaged in business or service, that, on at least 50
23 percent of its working days during the preceding calendar quarter
24 or preceding calendar year, employed at least one, but no more
25 than 50, eligible employees, the majority of whom were employed
26 within this state, that was not formed primarily for purposes of
27 buying health care service plan contracts, and in which a bona fide
28 employer-employee relationship exists. For plan years commencing
29 on or after January 1, 2016, any person, firm, proprietary or
30 nonprofit corporation, partnership, public agency, or association
31 that is actively engaged in business or service, that, on at least 50
32 percent of its working days during the preceding calendar quarter
33 or preceding calendar year, employed at least one, but no more
34 than 100, ~~eligible~~ employees, the majority of whom were employed
35 within this state, that was not formed primarily for purposes of
36 buying health care service plan contracts, and in which a bona fide
37 employer-employee relationship exists. In determining whether
38 to apply the calendar quarter or calendar year test, a health care
39 service plan shall use the test that ensures eligibility if only one
40 test would establish eligibility. In determining the number of

1 eligible ~~employees~~, *employees or employees*, companies that are
2 affiliated companies and that are eligible to file a combined tax
3 return for purposes of state taxation shall be considered one
4 employer. Subsequent to the issuance of a health care service plan
5 contract to a small employer pursuant to this article, and for the
6 purpose of determining eligibility, the size of a small employer
7 shall be determined annually. Except as otherwise specifically
8 provided in this article, provisions of this article that apply to a
9 small employer shall continue to apply until the plan contract
10 anniversary following the date the employer no longer meets the
11 requirements of this definition. It includes any small employer as
12 defined in this paragraph who purchases coverage through a
13 guaranteed association, and any employer purchasing coverage
14 for employees through a guaranteed association. This subparagraph
15 shall be implemented to the extent consistent with PPACA, except
16 that the minimum requirement of one employee shall be
17 implemented only to the extent required by PPACA.

18 (B) Any guaranteed association, as defined in subdivision (l),
19 that purchases health coverage for members of the association.

20 (2) For plan years commencing on or after January 1, 2014, the
21 definition of an employer, for purposes of determining whether
22 an employer with one employee shall include sole proprietors,
23 certain owners of “S” corporations, or other individuals, shall be
24 consistent with Section 1304 of PPACA.

25 (3) *For plan years commencing on or after January 1, 2016,*
26 *the definition of small employer, for purposes of determining the*
27 *number of employees, shall be determined using the method for*
28 *counting full-time equivalent employees set forth in Section*
29 *4980H(c)(2) of the Internal Revenue Code.*

30 (l) “Guaranteed association” means a nonprofit organization
31 comprised of a group of individuals or employers who associate
32 based solely on participation in a specified profession or industry,
33 accepting for membership any individual or employer meeting its
34 membership criteria, and that (1) includes one or more small
35 employers as defined in subparagraph (A) of paragraph (1) of
36 subdivision (k), (2) does not condition membership directly or
37 indirectly on the health or claims history of any person, (3) uses
38 membership dues solely for and in consideration of the membership
39 and membership benefits, except that the amount of the dues shall
40 not depend on whether the member applies for or purchases

1 insurance offered to the association, (4) is organized and
2 maintained in good faith for purposes unrelated to insurance, (5)
3 has been in active existence on January 1, 1992, and for at least
4 five years prior to that date, (6) has included health insurance as
5 a membership benefit for at least five years prior to January 1,
6 1992, (7) has a constitution and bylaws, or other analogous
7 governing documents that provide for election of the governing
8 board of the association by its members, (8) offers any plan contract
9 that is purchased to all individual members and employer members
10 in this state, (9) includes any member choosing to enroll in the
11 plan contracts offered to the association provided that the member
12 has agreed to make the required premium payments, and (10)
13 covers at least 1,000 persons with the health care service plan with
14 which it contracts. The requirement of 1,000 persons may be met
15 if component chapters of a statewide association contracting
16 separately with the same carrier cover at least 1,000 persons in the
17 aggregate.

18 This subdivision applies regardless of whether a contract issued
19 by a plan is with an association, or a trust formed for or sponsored
20 by an association, to administer benefits for association members.

21 For purposes of this subdivision, an association formed by a
22 merger of two or more associations after January 1, 1992, and
23 otherwise meeting the criteria of this subdivision shall be deemed
24 to have been in active existence on January 1, 1992, if its
25 predecessor organizations had been in active existence on January
26 1, 1992, and for at least five years prior to that date and otherwise
27 met the criteria of this subdivision.

28 (m) "Members of a guaranteed association" means any
29 individual or employer meeting the association's membership
30 criteria if that person is a member of the association and chooses
31 to purchase health coverage through the association. At the
32 association's discretion, it also may include employees of
33 association members, association staff, retired members, retired
34 employees of members, and surviving spouses and dependents of
35 deceased members. However, if an association chooses to include
36 these persons as members of the guaranteed association, the
37 association shall make that election in advance of purchasing a
38 plan contract. Health care service plans may require an association
39 to adhere to the membership composition it selects for up to 12
40 months.

(n) “Affiliation period” means a period that, under the terms of the health care service plan contract, must expire before health care services under the contract become effective.

(o) “Grandfathered health plan” has the meaning set forth in Section 1251 of PPACA.

(p) “Nongrandfathered small employer health care service plan contract” means a small employer health care service plan contract that is not a grandfathered health plan.

(q) “Plan year” has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations.

(r) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(s) “Small employer health care service plan contract” means a health care service plan contract issued to a small employer.

(t) “Waiting period” means a period that is required to pass with respect to an employee before the employee is eligible to be covered for benefits under the terms of the contract.

(u) “Registered domestic partner” means a person who has established a domestic partnership as described in Section 297 of the Family Code.

(v) “Family” means the subscriber and his or her dependent or dependents.

(w) “Health benefit plan” means a health care service plan contract that provides medical, hospital, and surgical benefits for the covered eligible employees of a small employer and their dependents. The term does not include coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement coverage, or coverage under a specialized health care service plan contract.

SECTION 1.

SEC. 2. Section 1399.849 of the Health and Safety Code is amended to read:

1399.849. (a) (1) On and after October 1, 2013, a plan shall fairly and affirmatively offer, market, and sell all of the plan’s health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the plan provides or arranges for the

provision of health care services. A plan shall limit enrollment in individual health benefit plans to open enrollment periods, annual enrollment periods, and special enrollment periods as provided in subdivisions (c) and (d).

(2) A plan shall allow the subscriber of an individual health benefit plan to add a dependent to the subscriber's plan at the option of the subscriber, consistent with the open enrollment, annual enrollment, and special enrollment period requirements in this section.

(b) An individual health benefit plan issued, amended, or renewed on or after January 1, 2014, shall not impose any preexisting condition provision upon any individual.

(c) (1) A plan shall provide an initial open enrollment period from October 1, 2013, to March 31, 2014, inclusive, an annual enrollment period for the policy year beginning on January 1, 2015, from November 15, 2014, to February 15, 2015, inclusive, and annual enrollment periods for policy years beginning on or after January 1, 2016, from November 1, of the preceding calendar year, to January 31 of the benefit year, inclusive.

(2) Pursuant to Section 147.104(b)(2) of Title 45 of the Code of Federal Regulations, for individuals enrolled in noncalendar year individual health plan contracts, a plan shall also provide a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.

(d) (1) Subject to paragraph (2), commencing January 1, 2014, a plan shall allow an individual to enroll in or change individual health benefit plans as a result of the following triggering events:

(A) He or she or his or her dependent loses minimum essential coverage. For purposes of this paragraph, the following definitions shall apply:

(i) "Minimum essential coverage" has the same meaning as that term is defined in subsection (f) of Section 5000A of the Internal Revenue Code (26 U.S.C. Sec. 5000A).

(ii) "Loss of minimum essential coverage" includes, but is not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code. "Loss of minimum essential coverage" also includes loss of that coverage for a reason that is not due to the fault of the individual.

1 (iii) “Loss of minimum essential coverage” does not include
2 loss of that coverage due to the individual’s failure to pay
3 premiums on a timely basis or situations allowing for a rescission,
4 subject to clause (ii) and Sections 1389.7 and 1389.21.

5 (B) He or she gains a dependent or becomes a dependent.

6 (C) He or she is mandated to be covered as a dependent pursuant
7 to a valid state or federal court order.

8 (D) He or she has been released from incarceration.

9 (E) His or her health coverage issuer substantially violated a
10 material provision of the health coverage contract.

11 (F) He or she gains access to new health benefit plans as a result
12 of a permanent move.

13 (G) He or she was receiving services from a contracting provider
14 under another health benefit plan, as defined in Section 1399.845
15 of this code or Section 10965 of the Insurance Code, for one of
16 the conditions described in subdivision (c) of Section 1373.96 of
17 this code and that provider is no longer participating in the health
18 benefit plan.

19 (H) He or she demonstrates to the Exchange, with respect to
20 health benefit plans offered through the Exchange, or to the
21 department, with respect to health benefit plans offered outside
22 the Exchange, that he or she did not enroll in a health benefit plan
23 during the immediately preceding enrollment period available to
24 the individual because he or she was misinformed that he or she
25 was covered under minimum essential coverage.

26 (I) He or she is a member of the reserve forces of the United
27 States military returning from active duty or a member of the
28 California National Guard returning from active duty service under
29 Title 32 of the United States Code.

30 (J) With respect to individual health benefit plans offered
31 through the Exchange, in addition to the triggering events listed
32 in this paragraph, any other events listed in Section 155.420(d) of
33 Title 45 of the Code of Federal Regulations.

34 (2) With respect to individual health benefit plans offered
35 outside the Exchange, an individual shall have 60 days from the
36 date of a triggering event identified in paragraph (1) to apply for
37 coverage from a health care service plan subject to this section.
38 With respect to individual health benefit plans offered through the
39 Exchange, an individual shall have 60 days from the date of a
40 triggering event identified in paragraph (1) to select a plan offered

1 through the Exchange, unless a longer period is provided in Part
2 155 (commencing with Section 155.10) of Subchapter B of Subtitle
3 A of Title 45 of the Code of Federal Regulations.

4 (e) With respect to individual health benefit plans offered
5 through the Exchange, the effective date of coverage required
6 pursuant to this section shall be consistent with the dates specified
7 in Section 155.410 or 155.420 of Title 45 of the Code of Federal
8 Regulations, as applicable. A dependent who is a registered
9 domestic partner pursuant to Section 297 of the Family Code shall
10 have the same effective date of coverage as a spouse.

11 (f) With respect to individual health benefit plans offered outside
12 the Exchange, the following provisions shall apply:

13 (1) After an individual submits a completed application form
14 for a plan contract, the health care service plan shall, within 30
15 days, notify the individual of the individual's actual premium
16 charges for that plan established in accordance with Section
17 1399.855. The individual shall have 30 days in which to exercise
18 the right to buy coverage at the quoted premium charges.

19 (2) With respect to an individual health benefit plan for which
20 an individual applies during the initial open enrollment period
21 described in subdivision (c), when the subscriber submits a
22 premium payment, based on the quoted premium charges, and that
23 payment is delivered or postmarked, whichever occurs earlier, by
24 December 15, 2013, coverage under the individual health benefit
25 plan shall become effective no later than January 1, 2014. When
26 that payment is delivered or postmarked within the first 15 days
27 of any subsequent month, coverage shall become effective no later
28 than the first day of the following month. When that payment is
29 delivered or postmarked between December 16, 2013, to December
30 31, 2013, inclusive, or after the 15th day of any subsequent month,
31 coverage shall become effective no later than the first day of the
32 second month following delivery or postmark of the payment.

33 (3) With respect to an individual health benefit plan for which
34 an individual applies during the annual open enrollment period
35 described in subdivision (c), when the individual submits a
36 premium payment, based on the quoted premium charges, and that
37 payment is delivered or postmarked, whichever occurs later, by
38 December 15, coverage shall become effective as of the following
39 January 1. When that payment is delivered or postmarked within
40 the first 15 days of any subsequent month, coverage shall become

1 effective no later than the first day of the following month. When
2 that payment is delivered or postmarked between December 16 to
3 December 31, inclusive, or after the 15th day of any subsequent
4 month, coverage shall become effective no later than the first day
5 of the second month following delivery or postmark of the
6 payment.

7 (4) With respect to an individual health benefit plan for which
8 an individual applies during a special enrollment period described
9 in subdivision (d), the following provisions shall apply:

10 (A) When the individual submits a premium payment, based
11 on the quoted premium charges, and that payment is delivered or
12 postmarked, whichever occurs earlier, within the first 15 days of
13 the month, coverage under the plan shall become effective no later
14 than the first day of the following month. When the premium
15 payment is neither delivered nor postmarked until after the 15th
16 day of the month, coverage shall become effective no later than
17 the first day of the second month following delivery or postmark
18 of the payment.

19 (B) Notwithstanding subparagraph (A), in the case of a birth,
20 adoption, or placement for adoption, the coverage shall be effective
21 on the date of birth, adoption, or placement for adoption.

22 (C) Notwithstanding subparagraph (A), in the case of marriage
23 or becoming a registered domestic partner or in the case where a
24 qualified individual loses minimum essential coverage, the
25 coverage effective date shall be the first day of the month following
26 the date the plan receives the request for special enrollment.

27 (g) (1) A health care service plan shall not establish rules for
28 eligibility, including continued eligibility, of any individual to
29 enroll under the terms of an individual health benefit plan based
30 on any of the following factors:

31 (A) Health status.

32 (B) Medical condition, including physical and mental illnesses.

33 (C) Claims experience.

34 (D) Receipt of health care.

35 (E) Medical history.

36 (F) Genetic information.

37 (G) Evidence of insurability, including conditions arising out
38 of acts of domestic violence.

39 (H) Disability.

1 (I) Any other health status-related factor as determined by any
2 federal regulations, rules, or guidance issued pursuant to Section
3 2705 of the federal Public Health Service Act (Public Law 78-410).

4 (2) Notwithstanding Section 1389.1, a health care service plan
5 shall not require an individual applicant or his or her dependent
6 to fill out a health assessment or medical questionnaire prior to
7 enrollment under an individual health benefit plan. A health care
8 service plan shall not acquire or request information that relates
9 to a health status-related factor from the applicant or his or her
10 dependent or any other source prior to enrollment of the individual.

11 (h) (1) A health care service plan shall consider as a single risk
12 pool for rating purposes in the individual market the claims
13 experience of all insureds and all enrollees in all nongrandfathered
14 individual health benefit plans offered by that health care service
15 plan in this state, whether offered as health care service plan
16 contracts or individual health insurance policies, including those
17 insureds and enrollees who enroll in individual coverage through
18 the Exchange and insureds and enrollees who enroll in individual
19 coverage outside of the Exchange. Student health insurance
20 coverage, as that coverage is defined in Section 147.145(a) of Title
21 45 of the Code of Federal Regulations, shall not be included in a
22 health care service plan's single risk pool for individual coverage.

23 (2) Each calendar year, a health care service plan shall establish
24 an index rate for the individual market in the state based on the
25 total combined claims costs for providing essential health benefits,
26 as defined pursuant to Section 1302 of PPACA, within the single
27 risk pool required under paragraph (1). The index rate shall be
28 adjusted on a marketwide basis based on the total expected
29 marketwide payments and charges under the risk adjustment and
30 reinsurance programs established for the state pursuant to Sections
31 1343 and 1341 of PPACA and Exchange user fees, as described
32 in subdivision (d) of Section 156.80 of Title 45 of the Code of
33 Federal Regulations. The premium rate for all of the health benefit
34 plans in the individual market within the single risk pool required
35 under paragraph (1) shall use the applicable marketwide adjusted
36 index rate, subject only to the adjustments permitted under
37 paragraph (3).

38 (3) A health care service plan may vary premium rates for a
39 particular health benefit plan from its index rate based only on the
40 following actuarially justified plan-specific factors:

1 (A) The actuarial value and cost-sharing design of the health
2 benefit plan.

3 (B) The health benefit plan's provider network, delivery system
4 characteristics, and utilization management practices.

5 (C) The benefits provided under the health benefit plan that are
6 in addition to the essential health benefits, as defined pursuant to
7 Section 1302 of PPACA and Section 1367.005. These additional
8 benefits shall be pooled with similar benefits within the single risk
9 pool required under paragraph (1) and the claims experience from
10 those benefits shall be utilized to determine rate variations for
11 plans that offer those benefits in addition to essential health
12 benefits.

13 (D) With respect to catastrophic plans, as described in subsection
14 (e) of Section 1302 of PPACA, the expected impact of the specific
15 eligibility categories for those plans.

16 (E) Administrative costs, excluding user fees required by the
17 Exchange.

18 (i) This section shall only apply with respect to individual health
19 benefit plans for policy years on or after January 1, 2014.

20 (j) This section shall not apply to a grandfathered health plan.

21 (k) If Section 5000A of the Internal Revenue Code, as added
22 by Section 1501 of PPACA, is repealed or amended to no longer
23 apply to the individual market, as defined in Section 2791 of the
24 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91),
25 subdivisions (a), (b), and (g) shall become inoperative 12 months
26 after that repeal or amendment.

27 ~~SEC. 2.~~

28 *SEC. 3.* Section 127660 of the Health and Safety Code is
29 amended to read:

30 127660. (a) The Legislature hereby requests the University of
31 California to establish the California Health Benefit Review
32 Program to assess legislation proposing to mandate a benefit or
33 service, as defined in subdivision (d), and legislation proposing to
34 repeal a mandated benefit or service, as defined in subdivision (e),
35 and to prepare a written analysis with relevant data on the
36 following:

37 (1) Public health impacts, including, but not limited to, all of
38 the following:

39 (A) The impact on the health of the community, including the
40 reduction of communicable disease and the benefits of prevention

1 such as those provided by childhood immunizations and prenatal
2 care.

3 (B) The impact on the health of the community, including
4 diseases and conditions where disparities in outcomes associated
5 with the social determinants of health as well as gender, race,
6 sexual orientation, or gender identity are established in
7 peer-reviewed scientific and medical literature.

8 (C) The extent to which the benefit or service reduces premature
9 death and the economic loss associated with disease.

10 (2) Medical impacts, including, but not limited to, all of the
11 following:

12 (A) The extent to which the benefit or service is generally
13 recognized by the medical community as being effective in the
14 screening, diagnosis, or treatment of a condition or disease, as
15 demonstrated by a review of scientific and peer-reviewed medical
16 literature.

17 (B) The extent to which the benefit or service is generally
18 available and utilized by treating physicians.

19 (C) The contribution of the benefit or service to the health status
20 of the population, including the results of any research
21 demonstrating the efficacy of the benefit or service compared to
22 alternatives, including not providing the benefit or service.

23 (D) The extent to which mandating or repealing the benefits or
24 services would not diminish or eliminate access to currently
25 available health care benefits or services.

26 (3) Financial impacts, including, but not limited to, all of the
27 following:

28 (A) The extent to which the coverage or repeal of coverage will
29 increase or decrease the benefit or cost of the benefit or service.

30 (B) The extent to which the coverage or repeal of coverage will
31 increase the utilization of the benefit or service, or will be a
32 substitute for, or affect the cost of, alternative benefits or services.

33 (C) The extent to which the coverage or repeal of coverage will
34 increase or decrease the administrative expenses of health care
35 service plans and health insurers and the premium and expenses
36 of subscribers, enrollees, and policyholders.

37 (D) The impact of this coverage or repeal of coverage on the
38 total cost of health care.

39 (E) The potential cost or savings to the private sector, including
40 the impact on small employers as defined in paragraph (1) of

subdivision (I) of Section 1357, the Public Employees' Retirement System, other retirement systems funded by the state or by a local government, individuals purchasing individual health insurance, and publicly funded state health insurance programs, including the Medi-Cal program and the Healthy Families Program.

(F) The extent to which costs resulting from lack of coverage or repeal of coverage are or would be shifted to other payers, including both public and private entities.

(G) The extent to which mandating or repealing the proposed benefit or service would not diminish or eliminate access to currently available health care benefits or services.

(H) The extent to which the benefit or service is generally utilized by a significant portion of the population.

(I) The extent to which health care coverage for the benefit or service is already generally available.

(J) The level of public demand for health care coverage for the benefit or service, including the level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts, and the extent to which the mandated benefit or service is covered by self-funded employer groups.

(K) In assessing and preparing a written analysis of the financial impact of legislation proposing to mandate a benefit or service and legislation proposing to repeal a mandated benefit or service pursuant to this paragraph, the Legislature requests the University of California to use a certified actuary or other person with relevant knowledge and expertise to determine the financial impact.

(4) The impact on essential health benefits, as defined in Section 1367.005 of this code and Section 10112.27 of the Insurance Code, and the impact on the California Health Benefit Exchange.

(b) The Legislature further requests that the California Health Benefit Review Program assess legislation that impacts health insurance benefit design, cost sharing, premiums, and other health insurance topics.

(c) The Legislature requests that the University of California provide every analysis to the appropriate policy and fiscal committees of the Legislature not later than 60 days, or in a manner and pursuant to a timeline agreed to by the Legislature and the California Health Benefit Review Program, after receiving a request made pursuant to Section 127661. In addition, the Legislature

1 requests that the university post every analysis on the Internet and
2 make every analysis available to the public upon request.

3 (d) As used in this section, “legislation proposing to mandate a
4 benefit or service” means a proposed statute that requires a health
5 care service plan or a health insurer, or both, to do any of the
6 following:

7 (1) Permit a person insured or covered under the policy or
8 contract to obtain health care treatment or services from a particular
9 type of health care provider.

10 (2) Offer or provide coverage for the screening, diagnosis, or
11 treatment of a particular disease or condition.

12 (3) Offer or provide coverage of a particular type of health care
13 treatment or service, or of medical equipment, medical supplies,
14 or drugs used in connection with a health care treatment or service.

15 (e) As used in this section, “legislation proposing to repeal a
16 mandated benefit or service” means a proposed statute that, if
17 enacted, would become operative on or after January 1, 2008, and
18 would repeal an existing requirement that a health care service
19 plan or a health insurer, or both, do any of the following:

20 (1) Permit a person insured or covered under the policy or
21 contract to obtain health care treatment or services from a particular
22 type of health care provider.

23 (2) Offer or provide coverage for the screening, diagnosis, or
24 treatment of a particular disease or condition.

25 (3) Offer or provide coverage of a particular type of health care
26 treatment or service, or of medical equipment, medical supplies,
27 or drugs used in connection with a health care treatment or service.

28 ~~SEC. 3.~~

29 *SEC. 4.* Section 127662 of the Health and Safety Code is
30 amended to read:

31 127662. (a) In order to effectively support the University of
32 California and its work in implementing this chapter, there is
33 hereby established in the State Treasury, the Health Care Benefits
34 Fund. The university’s work in providing the bill analyses shall
35 be supported from the fund.

36 (b) For the 2010–11 to 2016–17 fiscal years, inclusive, each
37 health care service plan, except a specialized health care service
38 plan, and each health insurer, as defined in Section 106 of the
39 Insurance Code, shall be assessed an annual fee in an amount
40 determined through regulation. The amount of the fee shall be

determined by the Department of Managed Health Care and the Department of Insurance in consultation with the university and shall be limited to the amount necessary to fund the actual and necessary expenses of the university and its work in implementing this chapter. The total annual assessment on health care service plans and health insurers shall not exceed two million dollars (\$2,000,000).

(c) The Department of Managed Health Care and the Department of Insurance, in coordination with the university, shall assess the health care service plans and health insurers, respectively, for the costs required to fund the university's activities pursuant to subdivision (b).

(1) Health care service plans shall be notified of the assessment on or before June 15 of each year with the annual assessment notice issued pursuant to Section 1356. The assessment pursuant to this section is separate and independent of the assessments in Section 1356.

(2) Health insurers shall be noticed of the assessment in accordance with the notice for the annual assessment or quarterly premium tax revenues.

(3) The assessed fees required pursuant to subdivision (b) shall be paid on an annual basis no later than August 1 of each year. The Department of Managed Health Care and the Department of Insurance shall forward the assessed fees to the Controller for deposit in the Health Care Benefits Fund immediately following their receipt.

(4) "Health insurance," as used in this subdivision, does not include Medicare supplement, vision-only, dental-only, or CHAMPUS supplement insurance, or hospital indemnity, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

~~SEC. 4.~~

SEC. 5. Section 127664 of the Health and Safety Code is amended to read:

127664. The Legislature requests the University of California to submit a report to the Governor and the Legislature by January 1, 2017, regarding the implementation of this chapter. This report shall be submitted in compliance with Section 9795 of the Government Code.

~~SEC. 5.~~

~~SEC. 6.~~ Section 127665 of the Health and Safety Code is repealed.

~~SEC. 6.~~

~~SEC. 7.~~ Section 127665 is added to the Health and Safety Code, to read:

127665. This chapter shall become inoperative on July 1, 2017, and, as of January 1, 2018, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2018, deletes or extends the dates on which it becomes inoperative and is repealed.

~~SEC. 8.~~ *Section 10753 of the Insurance Code is amended to read:*

10753. (a) “Agent or broker” means a person or entity licensed under Chapter 5 (commencing with Section 1621) of Part 2 of Division 1.

(b) “Benefit plan design” means a specific health coverage product issued by a carrier to small employers, to trustees of associations that include small employers, or to individuals if the coverage is offered through employment or sponsored by an employer. It includes services covered and the levels of copayment and deductibles, and it may include the professional providers who are to provide those services and the sites where those services are to be provided. A benefit plan design may also be an integrated system for the financing and delivery of quality health care services which has significant incentives for the covered individuals to use the system.

(c) “Carrier” means a health insurer or any other entity that writes, issues, or administers health benefit plans that cover the employees of small employers, regardless of the situs of the contract or master policyholder.

(d) “Child” means a child described in Section 22775 of the Government Code and subdivisions (n) to (p), inclusive, of Section 599.500 of Title 2 of the California Code of Regulations.

(e) “Dependent” means the spouse or registered domestic partner, or child, of an eligible employee, subject to applicable terms of the health benefit plan covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage

1 at the same time it determines its membership composition pursuant
2 to subdivision (s).

3 (f) “Eligible employee” means either of the following:

4 (1) Any permanent employee who is actively engaged on a
5 full-time basis in the conduct of the business of the small employer
6 with a normal workweek of an average of 30 hours per week over
7 the course of a month, in the small employer’s regular place of
8 business, who has met any statutorily authorized applicable waiting
9 period requirements. The term includes sole proprietors or partners
10 of a partnership, if they are actively engaged on a full-time basis
11 in the small employer’s business, and they are included as
12 employees under a health benefit plan of a small employer, but
13 does not include employees who work on a part-time, temporary,
14 or substitute basis. It includes any eligible employee, as defined
15 in this paragraph, who obtains coverage through a guaranteed
16 association. Employees of employers purchasing through a
17 guaranteed association shall be deemed to be eligible employees
18 if they would otherwise meet the definition except for the number
19 of persons employed by the employer. A permanent employee
20 who works at least 20 hours but not more than 29 hours is deemed
21 to be an eligible employee if all four of the following apply:

22 (A) The employee otherwise meets the definition of an eligible
23 employee except for the number of hours worked.

24 (B) The employer offers the employee health coverage under a
25 health benefit plan.

26 (C) All similarly situated individuals are offered coverage under
27 the health benefit plan.

28 (D) The employee must have worked at least 20 hours per
29 normal workweek for at least 50 percent of the weeks in the
30 previous calendar quarter. The insurer may request any necessary
31 information to document the hours and time period in question,
32 including, but not limited to, payroll records and employee wage
33 and tax filings.

34 (2) Any member of a guaranteed association as defined in
35 subdivision (s).

36 (g) “Enrollee” means an eligible employee or dependent who
37 receives health coverage through the program from a participating
38 carrier.

39 (h) “Exchange” means the California Health Benefit Exchange
40 created by Section 100500 of the Government Code.

1 (i) “Financially impaired” means, for the purposes of this
2 chapter, a carrier that, on or after the effective date of this chapter,
3 is not insolvent and is either:

4 (1) Deemed by the commissioner to be potentially unable to
5 fulfill its contractual obligations.

6 (2) Placed under an order of rehabilitation or conservation by
7 a court of competent jurisdiction.

8 (j) “Health benefit plan” means a policy of health insurance, as
9 defined in Section 106, for the covered eligible employees of a
10 small employer and their dependents. The term does not include
11 coverage of Medicare services pursuant to contracts with the United
12 States government, or coverage that provides excepted benefits,
13 as described in Sections 2722 and 2791 of the federal Public Health
14 Service Act, subject to Section 10701.

15 (k) “In force business” means an existing health benefit plan
16 issued by the carrier to a small employer.

17 (l) “Late enrollee” means an eligible employee or dependent
18 who has declined health coverage under a health benefit plan
19 offered by a small employer at the time of the initial enrollment
20 period provided under the terms of the health benefit plan
21 consistent with the periods provided pursuant to Section 10753.05
22 and who subsequently requests enrollment in a health benefit plan
23 of that small employer, except where the employee or dependent
24 qualifies for a special enrollment period provided pursuant to
25 Section 10753.05. It also means any member of an association that
26 is a guaranteed association as well as any other person eligible to
27 purchase through the guaranteed association when that person has
28 failed to purchase coverage during the initial enrollment period
29 provided under the terms of the guaranteed association’s health
30 benefit plan consistent with the periods provided pursuant to
31 Section 10753.05 and who subsequently requests enrollment in
32 the plan, except where the employee or dependent qualifies for a
33 special enrollment period provided pursuant to Section 10753.05.

34 (m) “New business” means a health benefit plan issued to a
35 small employer that is not the carrier’s in force business.

36 (n) “Preexisting condition provision” means a policy provision
37 that excludes coverage for charges or expenses incurred during a
38 specified period following the insured’s effective date of coverage,
39 as to a condition for which medical advice, diagnosis, care, or

1 treatment was recommended or received during a specified period
2 immediately preceding the effective date of coverage.

3 (o) “Creditable coverage” means:

4 (1) Any individual or group policy, contract, or program, that
5 is written or administered by a health insurer, health care service
6 plan, fraternal benefits society, self-insured employer plan, or any
7 other entity, in this state or elsewhere, and that arranges or provides
8 medical, hospital, and surgical coverage not designed to supplement
9 other private or governmental plans. The term includes continuation
10 or conversion coverage but does not include accident only, credit,
11 coverage for onsite medical clinics, disability income, Medicare
12 supplement, long-term care, dental, vision, coverage issued as a
13 supplement to liability insurance, insurance arising out of a
14 workers’ compensation or similar law, automobile medical payment
15 insurance, or insurance under which benefits are payable with or
16 without regard to fault and that is statutorily required to be
17 contained in any liability insurance policy or equivalent
18 self-insurance.

19 (2) The federal Medicare Program pursuant to Title XVIII of
20 the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

21 (3) The Medicaid Program pursuant to Title XIX of the federal
22 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

23 (4) Any other publicly sponsored program, provided in this state
24 or elsewhere, of medical, hospital, and surgical care.

25 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
26 (Civilian Health and Medical Program of the Uniformed Services
27 (CHAMPUS)).

28 (6) A medical care program of the Indian Health Service or of
29 a tribal organization.

30 (7) A health plan offered under 5 U.S.C. Chapter 89
31 (commencing with Section 8901) (Federal Employees Health
32 Benefits Program (FEHBP)).

33 (8) A public health plan as defined in federal regulations
34 authorized by Section 2701(c)(1)(I) of the federal Public Health
35 Service Act, as amended by Public Law 104-191, the federal Health
36 Insurance Portability and Accountability Act of 1996.

37 (9) A health benefit plan under Section 5(e) of the federal Peace
38 Corps Act (22 U.S.C. Sec. 2504(e)).

1 (10) Any other creditable coverage as defined by subdivision
2 (c) of Section 2704 of Title XXVII of the federal Public Health
3 Service Act (42 U.S.C. Sec. 300gg-3(c)).

4 (p) “Rating period” means the period for which premium rates
5 established by a carrier are in effect and shall be no less than 12
6 months from the date of issuance or renewal of the health benefit
7 plan.

8 (q) (1) “Small employer” means either of the following:

9 (A) For plan years commencing on or after January 1, 2014,
10 and on or before December 31, 2015, any person, firm, proprietary
11 or nonprofit corporation, partnership, public agency, or association
12 that is actively engaged in business or service, that, on at least 50
13 percent of its working days during the preceding calendar quarter
14 or preceding calendar year, employed at least one, but no more
15 than 50, eligible employees, the majority of whom were employed
16 within this state, that was not formed primarily for purposes of
17 buying health benefit plans, and in which a bona fide
18 employer-employee relationship exists. For plan years commencing
19 on or after January 1, 2016, any person, firm, proprietary or
20 nonprofit corporation, partnership, public agency, or association
21 that is actively engaged in business or service, that, on at least 50
22 percent of its working days during the preceding calendar quarter
23 or preceding calendar year, employed at least one, but no more
24 than 100, ~~eligible~~ employees, the majority of whom were employed
25 within this state, that was not formed primarily for purposes of
26 buying health benefit plans, and in which a bona fide
27 employer-employee relationship exists. In determining whether
28 to apply the calendar quarter or calendar year test, a carrier shall
29 use the test that ensures eligibility if only one test would establish
30 eligibility. In determining the number of ~~eligible employees,~~
31 *employees or employees*, companies that are affiliated companies
32 and that are eligible to file a combined tax return for purposes of
33 state taxation shall be considered one employer. Subsequent to the
34 issuance of a health benefit plan to a small employer pursuant to
35 this chapter, and for the purpose of determining eligibility, the size
36 of a small employer shall be determined annually. Except as
37 otherwise specifically provided in this chapter, provisions of this
38 chapter that apply to a small employer shall continue to apply until
39 the plan contract anniversary following the date the employer no
40 longer meets the requirements of this definition. It includes any

1 small employer as defined in this subparagraph who purchases
2 coverage through a guaranteed association, and any employer
3 purchasing coverage for employees through a guaranteed
4 association. This subparagraph shall be implemented to the extent
5 consistent with PPACA, except that the minimum requirement of
6 one employee shall be implemented only to the extent required by
7 PPACA.

8 (B) Any guaranteed association, as defined in subdivision (r),
9 that purchases health coverage for members of the association.

10 (2) For plan years commencing on or after January 1, 2014, the
11 definition of an employer, for purposes of determining whether
12 an employer with one employee shall include sole proprietors,
13 certain owners of “S” corporations, or other individuals, shall be
14 consistent with Section 1304 of PPACA.

15 (3) *For plan years commencing on or after January 1, 2016,*
16 *the definition of small employer, for purposes of determining the*
17 *number of employees, shall be determined using the method for*
18 *counting full-time equivalent employees set forth in Section*
19 *4980H(c)(2) of the Internal Revenue Code.*

20 (r) “Guaranteed association” means a nonprofit organization
21 comprised of a group of individuals or employers who associate
22 based solely on participation in a specified profession or industry,
23 accepting for membership any individual or employer meeting its
24 membership criteria which (1) includes one or more small
25 employers as defined in subparagraph (A) of paragraph (1) of
26 subdivision (q), (2) does not condition membership directly or
27 indirectly on the health or claims history of any person, (3) uses
28 membership dues solely for and in consideration of the membership
29 and membership benefits, except that the amount of the dues shall
30 not depend on whether the member applies for or purchases
31 insurance offered by the association, (4) is organized and
32 maintained in good faith for purposes unrelated to insurance, (5)
33 has been in active existence on January 1, 1992, and for at least
34 five years prior to that date, (6) has been offering health insurance
35 to its members for at least five years prior to January 1, 1992, (7)
36 has a constitution and bylaws, or other analogous governing
37 documents that provide for election of the governing board of the
38 association by its members, (8) offers any benefit plan design that
39 is purchased to all individual members and employer members in
40 this state, (9) includes any member choosing to enroll in the benefit

1 plan design offered to the association provided that the member
2 has agreed to make the required premium payments, and (10)
3 covers at least 1,000 persons with the carrier with which it
4 contracts. The requirement of 1,000 persons may be met if
5 component chapters of a statewide association contracting
6 separately with the same carrier cover at least 1,000 persons in the
7 aggregate.

8 This subdivision applies regardless of whether a master policy
9 by an admitted insurer is delivered directly to the association or a
10 trust formed for or sponsored by an association to administer
11 benefits for association members.

12 For purposes of this subdivision, an association formed by a
13 merger of two or more associations after January 1, 1992, and
14 otherwise meeting the criteria of this subdivision shall be deemed
15 to have been in active existence on January 1, 1992, if its
16 predecessor organizations had been in active existence on January
17 1, 1992, and for at least five years prior to that date and otherwise
18 met the criteria of this subdivision.

19 (s) “Members of a guaranteed association” means any individual
20 or employer meeting the association’s membership criteria if that
21 person is a member of the association and chooses to purchase
22 health coverage through the association. At the association’s
23 discretion, it may also include employees of association members,
24 association staff, retired members, retired employees of members,
25 and surviving spouses and dependents of deceased members.
26 However, if an association chooses to include those persons as
27 members of the guaranteed association, the association must so
28 elect in advance of purchasing coverage from a plan. Health plans
29 may require an association to adhere to the membership
30 composition it selects for up to 12 months.

31 (t) “Grandfathered health plan” has the meaning set forth in
32 Section 1251 of PPACA.

33 (u) “Nongrandfathered health benefit plan” means a health
34 benefit plan that is not a grandfathered health plan.

35 (v) “Plan year” has the meaning set forth in Section 144.103 of
36 Title 45 of the Code of Federal Regulations.

37 (w) “PPACA” means the federal Patient Protection and
38 Affordable Care Act (Public Law 111-148), as amended by the
39 federal Health Care and Education Reconciliation Act of 2010

(Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(x) “Waiting period” means a period that is required to pass with respect to the employee before the employee is eligible to be covered for benefits under the terms of the contract.

(y) “Registered domestic partner” means a person who has established a domestic partnership as described in Section 297 of the Family Code.

(z) “Family” means the policyholder and his or her dependents.

~~SEC. 7.~~

SEC. 9. Section 10965.3 of the Insurance Code is amended to read:

10965.3. (a) (1) On and after October 1, 2013, a health insurer shall fairly and affirmatively offer, market, and sell all of the insurer’s health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the insurer provides or arranges for the provision of health care services. A health insurer shall limit enrollment in individual health benefit plans to open enrollment periods, annual enrollment periods, and special enrollment periods as provided in subdivisions (c) and (d).

(2) A health insurer shall allow the policyholder of an individual health benefit plan to add a dependent to the policyholder’s health benefit plan at the option of the policyholder, consistent with the open enrollment, annual enrollment, and special enrollment period requirements in this section.

(b) An individual health benefit plan issued, amended, or renewed on or after January 1, 2014, shall not impose any preexisting condition provision upon any individual.

(c) (1) A health insurer shall provide an initial open enrollment period from October 1, 2013, to March 31, 2014, inclusive, an annual enrollment period for the policy year beginning on January 1, 2015, from November 15, 2014, to February 15, 2015, inclusive, and annual enrollment periods for policy years beginning on or after January 1, 2016, from November 1, of the preceding calendar year, to January 31 of the benefit year, inclusive.

(2) Pursuant to Section 147.104(b)(2) of Title 45 of the Code of Federal Regulations, for individuals enrolled in noncalendar year individual health plan contracts, a health insurer shall also provide a limited open enrollment period beginning on the date

1 that is 30 calendar days prior to the date the policy year ends in
2 2014.

3 (d) (1) Subject to paragraph (2), commencing January 1, 2014,
4 a health insurer shall allow an individual to enroll in or change
5 individual health benefit plans as a result of the following triggering
6 events:

7 (A) He or she or his or her dependent loses minimum essential
8 coverage. For purposes of this paragraph, both of the following
9 definitions shall apply:

10 (i) “Minimum essential coverage” has the same meaning as that
11 term is defined in subsection (f) of Section 5000A of the Internal
12 Revenue Code (26 U.S.C. Sec. 5000A).

13 (ii) “Loss of minimum essential coverage” includes, but is not
14 limited to, loss of that coverage due to the circumstances described
15 in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the
16 Code of Federal Regulations and the circumstances described in
17 Section 1163 of Title 29 of the United States Code. “Loss of
18 minimum essential coverage” also includes loss of that coverage
19 for a reason that is not due to the fault of the individual.

20 (iii) “Loss of minimum essential coverage” does not include
21 loss of that coverage due to the individual’s failure to pay
22 premiums on a timely basis or situations allowing for a rescission,
23 subject to clause (ii) and Sections 10119.2 and 10384.17.

24 (B) He or she gains a dependent or becomes a dependent.

25 (C) He or she is mandated to be covered as a dependent pursuant
26 to a valid state or federal court order.

27 (D) He or she has been released from incarceration.

28 (E) His or her health coverage issuer substantially violated a
29 material provision of the health coverage contract.

30 (F) He or she gains access to new health benefit plans as a result
31 of a permanent move.

32 (G) He or she was receiving services from a contracting provider
33 under another health benefit plan, as defined in Section 10965 of
34 this code or Section 1399.845 of the Health and Safety Code, for
35 one of the conditions described in subdivision (a) of Section
36 10133.56 of this code and that provider is no longer participating
37 in the health benefit plan.

38 (H) He or she demonstrates to the Exchange, with respect to
39 health benefit plans offered through the Exchange, or to the
40 department, with respect to health benefit plans offered outside

1 the Exchange, that he or she did not enroll in a health benefit plan
2 during the immediately preceding enrollment period available to
3 the individual because he or she was misinformed that he or she
4 was covered under minimum essential coverage.

5 (I) He or she is a member of the reserve forces of the United
6 States military returning from active duty or a member of the
7 California National Guard returning from active duty service under
8 Title 32 of the United States Code.

9 (J) With respect to individual health benefit plans offered
10 through the Exchange, in addition to the triggering events listed
11 in this paragraph, any other events listed in Section 155.420(d) of
12 Title 45 of the Code of Federal Regulations.

13 (2) With respect to individual health benefit plans offered
14 outside the Exchange, an individual shall have 60 days from the
15 date of a triggering event identified in paragraph (1) to apply for
16 coverage from a health care service plan subject to this section.
17 With respect to individual health benefit plans offered through the
18 Exchange, an individual shall have 60 days from the date of a
19 triggering event identified in paragraph (1) to select a plan offered
20 through the Exchange, unless a longer period is provided in Part
21 155 (commencing with Section 155.10) of Subchapter B of Subtitle
22 A of Title 45 of the Code of Federal Regulations.

23 (e) With respect to individual health benefit plans offered
24 through the Exchange, the effective date of coverage required
25 pursuant to this section shall be consistent with the dates specified
26 in Section 155.410 or 155.420 of Title 45 of the Code of Federal
27 Regulations, as applicable. A dependent who is a registered
28 domestic partner pursuant to Section 297 of the Family Code shall
29 have the same effective date of coverage as a spouse.

30 (f) With respect to an individual health benefit plan offered
31 outside the Exchange, the following provisions shall apply:

32 (1) After an individual submits a completed application form
33 for a plan, the insurer shall, within 30 days, notify the individual
34 of the individual's actual premium charges for that plan established
35 in accordance with Section 10965.9. The individual shall have 30
36 days in which to exercise the right to buy coverage at the quoted
37 premium charges.

38 (2) With respect to an individual health benefit plan for which
39 an individual applies during the initial open enrollment period
40 described in subdivision (c), when the policyholder submits a

1 premium payment, based on the quoted premium charges, and that
2 payment is delivered or postmarked, whichever occurs earlier, by
3 December 15, 2013, coverage under the individual health benefit
4 plan shall become effective no later than January 1, 2014. When
5 that payment is delivered or postmarked within the first 15 days
6 of any subsequent month, coverage shall become effective no later
7 than the first day of the following month. When that payment is
8 delivered or postmarked between December 16, 2013, to December
9 31, 2013, inclusive, or after the 15th day of any subsequent month,
10 coverage shall become effective no later than the first day of the
11 second month following delivery or postmark of the payment.

12 (3) With respect to an individual health benefit plan for which
13 an individual applies during the annual open enrollment period
14 described in subdivision (c), when the individual submits a
15 premium payment, based on the quoted premium charges, and that
16 payment is delivered or postmarked, whichever occurs later, by
17 December 15, coverage shall become effective as of the following
18 January 1. When that payment is delivered or postmarked within
19 the first 15 days of any subsequent month, coverage shall become
20 effective no later than the first day of the following month. When
21 that payment is delivered or postmarked between December 16 to
22 December 31, inclusive, or after the 15th day of any subsequent
23 month, coverage shall become effective no later than the first day
24 of the second month following delivery or postmark of the
25 payment.

26 (4) With respect to an individual health benefit plan for which
27 an individual applies during a special enrollment period described
28 in subdivision (d), the following provisions shall apply:

29 (A) When the individual submits a premium payment, based
30 on the quoted premium charges, and that payment is delivered or
31 postmarked, whichever occurs earlier, within the first 15 days of
32 the month, coverage under the plan shall become effective no later
33 than the first day of the following month. When the premium
34 payment is neither delivered nor postmarked until after the 15th
35 day of the month, coverage shall become effective no later than
36 the first day of the second month following delivery or postmark
37 of the payment.

38 (B) Notwithstanding subparagraph (A), in the case of a birth,
39 adoption, or placement for adoption, the coverage shall be effective
40 on the date of birth, adoption, or placement for adoption.

(C) Notwithstanding subparagraph (A), in the case of marriage or becoming a registered domestic partner or in the case where a qualified individual loses minimum essential coverage, the coverage effective date shall be the first day of the month following the date the insurer receives the request for special enrollment.

(g) (1) A health insurer shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of an individual health benefit plan based on any of the following factors:

(A) Health status.

(B) Medical condition, including physical and mental illnesses.

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability, including conditions arising out of acts of domestic violence.

(H) Disability.

(I) Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act (Public Law 78-410).

(2) Notwithstanding subdivision (c) of Section 10291.5, a health insurer shall not require an individual applicant or his or her dependent to fill out a health assessment or medical questionnaire prior to enrollment under an individual health benefit plan. A health insurer shall not acquire or request information that relates to a health status-related factor from the applicant or his or her dependent or any other source prior to enrollment of the individual.

(h) (1) A health insurer shall consider as a single risk pool for rating purposes in the individual market the claims experience of all insureds and enrollees in all nongrandfathered individual health benefit plans offered by that insurer in this state, whether offered as health care service plan contracts or individual health insurance policies, including those insureds and enrollees who enroll in individual coverage through the Exchange and insureds and enrollees who enroll in individual coverage outside the Exchange. Student health insurance coverage, as such coverage is defined in Section 147.145(a) of Title 45 of the Code of Federal Regulations, shall not be included in a health insurer's single risk pool for individual coverage.

(2) Each calendar year, a health insurer shall establish an index rate for the individual market in the state based on the total combined claims costs for providing essential health benefits, as defined pursuant to Section 1302 of PPACA, within the single risk pool required under paragraph (1). The index rate shall be adjusted on a marketwide basis based on the total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA and Exchange user fees, as described in subdivision (d) of Section 156.80 of Title 45 of the Code of Federal Regulations. The premium rate for all of the health benefit plans in the individual market within the single risk pool required under paragraph (1) shall use the applicable marketwide adjusted index rate, subject only to the adjustments permitted under paragraph (3).

(3) A health insurer may vary premium rates for a particular health benefit plan from its index rate based only on the following actuarially justified plan-specific factors:

(A) The actuarial value and cost-sharing design of the health benefit plan.

(B) The health benefit plan's provider network, delivery system characteristics, and utilization management practices.

(C) The benefits provided under the health benefit plan that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA and Section 10112.27. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.

(D) With respect to catastrophic plans, as described in subsection (e) of Section 1302 of PPACA, the expected impact of the specific eligibility categories for those plans.

(E) Administrative costs, excluding any user fees required by the Exchange.

(i) This section shall only apply with respect to individual health benefit plans for policy years on or after January 1, 2014.

(j) This section shall not apply to a grandfathered health plan.

(k) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer

1 apply to the individual market, as defined in Section 2791 of the
2 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91),
3 subdivisions (a), (b), and (g) shall become inoperative 12 months
4 after the date of that repeal or amendment and individual health
5 care benefit plans shall thereafter be subject to Sections 10901.2,
6 10951, and 10953.

7 ~~SEC. 8.~~

8 *SEC. 10.* No reimbursement is required by this act pursuant to
9 Section 6 of Article XIII B of the California Constitution because
10 the only costs that may be incurred by a local agency or school
11 district will be incurred because this act creates a new crime or
12 infraction, eliminates a crime or infraction, or changes the penalty
13 for a crime or infraction, within the meaning of Section 17556 of
14 the Government Code, or changes the definition of a crime within
15 the meaning of Section 6 of Article XIII B of the California
16 Constitution.

17 ~~SEC. 9.~~

18 *SEC. 11.* This act is an urgency statute necessary for the
19 immediate preservation of the public peace, health, or safety within
20 the meaning of Article IV of the Constitution and shall go into
21 immediate effect. The facts constituting the necessity are:

22 In order to maintain appropriate standards of accuracy and
23 efficiency with respect to matters relating to health care coverage
24 in California, by adjusting the next open enrollment period for the
25 individual health care coverage market as needed to comply with
26 federal law, and ensuring that the University of California is
27 provided with sufficient advance notice regarding the continuing
28 duties of the university to plan and carry out necessary health care
29 benefit research and analysis as requested pursuant to this act, it
30 is necessary that this act take effect immediately.